SURVEY 3

Referrals from general practitioners to a social services department

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SUMMARY. One year's referrals from general practitioners to a social services department were studied. There was a low referral rate and a bias towards women, the elderly and the less affluent. The referrals were predominantly made for practical help with problems of ill health. A high proportion of clients were allocated to non-social work staff, and the social service intervention, generally of short duration, showed a sympathetic response to the practical requests of general practitioners. The limited use of social workers by doctors is considered to be the result of ignorance or scepticism about psychodynamic social work skills. Closer liaison between general practitioners and social workers, and a clearer presentation by social workers of their professional skills, are suggested solutions to this problem.

Introduction

IN recent years there has been a growth of interest in general practice–social work co-operation. Research has concentrated on attachment schemes, viewed as a means of providing a social work service to a client population not generally encountered in a local authority setting. This has shown that a wide variety of clients and problems are encountered in general practice, requiring all aspects of social work knowledge and skills (Collins, 1965; Forman and Fairbairn, 1968; Goldberg and Neill, 1972). This research has shown that the social composition of the client population is wider in attachment schemes than in the local authority setting, and that attachment schemes have proved more successful than liaison schemes (Corney and Briscoe, 1977; Corney, 1980b; Corney and Bowen, 1980). Where attachment schemes have operated, general practitioners have gained a clearer idea of the work and contribution of social workers (Dickinson and Harper, 1968; Cooper, 1971; Graham and Sher, 1976). The views of both professionals and clients in these schemes have been positive (Ratoff and Pearson, 1970; Bowen *et al.*, 1978; Williams and Clare, 1979; Corney, 1981a). Evaluative studies suggest that social work may be effective with some client groups, though more research is needed (Cooper *et al.*, 1975; Corney, 1981b). Finally, the factors influencing the success of attachment schemes have been studied (de Gruchy, 1970–71; Ratoff *et al.*, 1974; Corney, 1980a).

However, little is known about the pattern of referrals to social service departments where no attachment or liaison schemes operate (Theophilus, 1973) and nothing is known about the outcome of these referrals. It is particularly important to know more because there are so few attachment schemes, and because general practitioners have a potentially central role as referrers (Glampson *et al.*, 1977; Gilchrist *et al.*, 1978). This study examines the kinds of referrals made by general practitioners and the nature and scope of the social service response.

Area and method

The area studied is served by the Dereham social services office and is largely rural, except for the two towns of Dereham and Swaffham. The population is 42,000, and the agricultural sector, though large, is smaller than the service or industrial sectors (Breckland, 1977). The two teams which serve this area consist of two team leaders, nine social workers (of whom two were unqualified), two social work assistants, two home help organizers and one occupational therapist. A record was kept of all referrals made by general practitioners to the social service office during 1980. At the referral stage demographic details and the reason for referral were noted. Although part of the continuing office routine, the data recorded for each referral were checked for accuracy by the social service officer subsequently involved. Following intervention, the social service officers were interviewed and details of their involvement were taken on standardized forms which focussed on the problems identified, the action taken

Table 1. Age and sex of people referred.

	Male		Female	
Age	Number	Percentage	Number	Percentage
0–20	1	*0.6*	1	*0.6*
21–40	5	*2.8*	15	*8.5*
41–65	9	*5.1*	10	*5.7*
66 and over	46	*26.1*	89	*50.6*
Total	61	*34.6*	115	*65.4*

Table 2. Nature of housing tenure.

	Referral group		Whole area*
	Number	Percentage**	Percentage
Owner occupied	85	*54.5*	*59.4*
Local authority	49	*31.4*	*21.1*
Private rented	21	*13.5*	*19.5*
Homeless	1	*0.6*	—
Unknown	20	—	—
Total	176	*100.0*	*100.0*

*Comprising Dereham and Swaffham urban districts, and Mitford and Launditch rural district. Although not exactly coterminous with the area studied, it is a reasonably close approximation. No more accurate figures are available (*Census, 1971, England and Wales, County Report: Norfolk, Part 1* (HMSO, 1973), Table 25).
**Percentage figures given only for known housing tenure.

and the degree of social work involvement. Problems and activities were categorized in a manner similar to the systems developed by Fitzgerald (1978) and Goldberg and colleagues (1977), so that comparisons with existing studies of general practice-social work co-operation were possible. Where more than one person was the subject of intervention arising out of one referral, the social service officer was asked to identify who was the primary subject of intervention. The research ended four months into 1981, by which time intervention had ended in the majority of cases.

Results

Number of referrals

During 1980, 176 referrals were made by 28 general practitioners involving 169 clients. This number comprised about 15 per cent of all referrals to the social services office, a figure exceeded only by self-referrals and referrals from relatives and friends. Over half of those referred (89) had experienced previous social service involvement. The highest number of referrals made by any single general practitioner was 13; 14 doctors made six or fewer referrals. The referral rate was considerably lower than that documented in attachment schemes (Collins, 1965; Goldberg and Neill, 1972; Corney and Bowen, 1980).

Table 3. Reason for referral.

	Number	Percentage
Problems associated with ill health (including serious mental illness)	143	*70.4*
Relationship, emotional and minor mental ill-health problems	44	*21.7*
Material and practical problems	15	*7.4*
Other	1	*0.5*
Total	203	*100.0*

Demographic characteristics

Table 1 shows the age and sex of the people referred and reveals a predominance of females, a finding which is consistent with the experience of attachment schemes and the high female attendance at surgery (Goldberg and Neill, 1972; Corney, 1980b). The table also shows a predominance of the elderly. By contrast, few people under 21 were referred. Forty-two per cent of the clients were married, 12.5 per cent were single, 4.6 per cent were divorced or separated and 40.9 per cent were widowed. The largest socio-economic group was pensioners. Of those of working age, 15 (8.5 per cent) were unemployed, 13 (7.4 per cent) were housewives, six were manual workers, one was a clerk and three were in professional or managerial occupations. Housing tenure (Table 2) did not reflect the socio-economic distribution of Table 1. However, all the elderly derived their income from pensions, and over half the non-elderly were in families receiving welfare benefits.

Reason for referral

Table 3 shows that there was a strong tendency for general practitioners to refer clients for problems associated with ill health, sometimes in combination with other problems. Altogether ill health was the primary problem presented in 80 per cent of referrals, the vast majority of which were among the elderly. The patients' medical problems led to largely practical requests, nearly 65 per cent of which were for aids, residential or day care, home help or meals on wheels. This confirms the value, noted in another study (McCulloch and Brown, 1970), that general practitioners place on the practical help social services can offer.

Allocation of referrals

Table 4 shows how the referrals were allocated. The high proportion who were not allocated to social workers is noteworthy. Yet few of the referrals not allocated or visited were obviously inappropriate. The main reasons for non-allocation were the death of the client, the refusal of the client to agree to the referral, or a change in circumstances following the referral which made the allocation unnecessary.

Social service officers' assessment of problems

The term 'social service officer' refers to all those employees of the social service department to whom referrals were allocated. This includes social workers, social work assistants, social work trainees, occupational therapists, home help organizers and administrative staff. Table 5 shows that the social service officers found health problems in the vast majority of referrals. These problems were particularly prevalent amongst the elderly. Emotional and relationship problems were more common among the non-elderly. The more complex referrals, where two or more types of problem were identified, were found almost entirely in clients allocated to social workers. While the occupational therapist and the home help organizer found few problems, other than illness, which were sufficiently serious for social service intervention, social workers identified relationship problems in 65 per cent of their clients. However, health problems were still the most important and were considered by social workers to be the primary problem in 57 per cent of their clients; relationship problems were considered primary in only 31 per cent of their clients.

Table 4. Allocation of referrals.

	Number	Percentage
Social workers	78	*44.3*
Social work assistants	16	*9.1*
Social work trainee	3	*1.7*
Occupational therapist	36	*20.5*
Home help organizer*	30	*17.0*
Administration	3	*1.7*
Referred to another social service area	2	*1.1*
Not allocated/visited	17	*9.7*

*Of the allocations to the home help organizer, six were also allocated to social workers, two to social work assistants and one to the occupational therapist.

Activities of social service staff

The importance attached to providing resources shows social services staff to have generally responded positively to the practical requests made by the general practitioner (Table 6). However, the amount of counselling by social workers reflects their concern with emotional and relationship problems. Table 7 shows that where social workers subsequently referred clients to other agencies, it was mainly for practical help. In nearly all cases, social workers informed the general practitioner of their activities, but rarely had detailed discussions about the management of cases.

Social work intervention

Contact between the client and the occupational therapist or home help organizer followed a fairly routine pattern of assessment visit plus follow-up visit, and, in the case of the home help organizer, periodic reviews. Table 8 shows that most social work clients received only short-term involvement and few interviews. Where relationship problems were primary, the period of involvement tended to be longer, although the number of interviews was much the same.

Discussion

Interpretation of the above results must take account of methodological difficulties inherent in a study of this kind. It was often difficult to determine the exact reason for referral from the general practitioner, since details were taken at different times by different duty social workers. This problem was compounded by the fact that some doctors made many of their referrals through their receptionist. A degree of consistency was achieved insofar as two questions were paramount for each duty social worker at referral stage: what is the nature of the problem referred, and what action is being requested?

A further difficulty lay in determining which categories of problems and activities most appropriately de-

Table 5. Social service officers' assessment of problems.

	Social service officer*		Social worker	
	Number	Percentage	Number	Percentage
Ill health (including major mental illness)	75	*47.2*	18	*18.6*
Relationship, emotional and minor mental illness	5	*3.1*	5	*5.1*
Material and practical	6	*3.8*	6	*6.2*
Relationship, health and practical	7	*4.4*	7	*7.2*
Health and practical	5	*3.1*	5	*5.1*
Health and relationship	51	*32.1*	48	*49.5*
Relationship and practical	4	*2.5*	4	*4.1*
Other	2	*1.3*	2	*2.1*
No problem	4	*2.5*	2	*2.1*
Total	159	*100.0*	97	*100.0*

*Includes all social service officers to whom referrals were allocated (see Table 4).

scribed social service intervention. Although the problem and activity categories were predetermined, it was the social service officer involved who decided which of these categories most appropriately described intervention. This decision inevitably involved some bias arising out of personal differences of emphasis in categorization, and is a problem common to this kind of study. I attempted to overcome this bias by discussing each case with the social service officer involved. However, this may simply have introduced a more systematic bias, arising out of the influence these discussions may have had on the perceptions of each social services officer.

Care should be taken not to claim too much from these data. There are no comparable studies of referrals direct from general practitioners to social services departments, and results may reflect characteristics special to the area. Furthermore, unlike attachment schemes, referrals were made not simply for social work support, but for the whole range of help social services can offer. Nonetheless, this study does complement the evidence from attachment schemes, and does much to reinforce the arguments of their proponents.

The pattern of referrals shows general practitioners to be using social services largely as an extension of the health services which can mobilize resources. The bias towards the elderly, problems of ill health and requests for practical help in the referrals reflect a fairly appropriate use of the home help and occupational therapy services. However, purely paramedical work would be considered by social workers to be only a small part of their full role.

Generally, few of the less vulnerable or higher status socio-economic groups were referred. There were virtually no referrals for child care problems and few relationship or financial and practical problems amongst the less affluent. Yet these are well within the ambit of social work knowledge and skills. The range of problems presented was not fundamentally altered by the social workers' assessments, and intervention was generally short term and practical. This is despite the fact that social workers consider their major professional skill to be emotional support and counselling, or in social work terminology 'casework' (Rees, 1978). Such counselling as was done by the social workers was frequently with relationship problems which were secondary to health problems.

The limited use made by the general practitioners of the social workers is unlikely to have reflected the spectrum of problems they confronted in the surgery. Certainly, the stigma attached to social service intervention—least strong for the elderly—may have influenced the social composition of referrals (Goldberg, 1979). It is also well established that general practitioners encounter a wide variety of social, emotional and practi-

Table 6. Activities of social service officers.

	Social service officers		Social workers	
	Number	Percentage	Number	Percentage
Providing aids	35	*12.5*	0	
Home help	30	*10.7*	0	
Meals on wheels	1	*0.4*	0	
Short-term care	27	*9.6*	27	*13.3*
Day care	8	*2.9*	8	*3.9*
Long-term care	6	*2.1*	6	*2.9*
Liaison and advocacy*	73	*26.1*	62	*30.5*
Counselling, advice and emotional support	92	*32.9*	92	*45.4*
Section 29 Mental Health Act	4	*1.4*	4	*2.0*
Other	4	*1.4*	4	*2.0*
Total	280	*100.0*	203	*100.0*

*Does not include subsequent contact with GPs.

Table 7. Referrals on to other agencies.

	Number	Percentage
Voluntary	8	*25.0*
DHSS	11	*34.4*
Housing	8	*25.0*
Ophthalmologist	2	*6.3*
Public health	1	*3.1*
Probation	1	*3.1*
Education	1	*3.1*
Total	32	*100.0*

Table 8. The number of interviews made by social workers and the duration of intervention.

	Referrals			Referrals	
Number of interviews	Number	Percentage	Time period	Number	Percentage
1	30	*30.9*	1 week or less	22	*22.7*
2–5	42	*43.3*	1 week to 1 month	20	*20.6*
6–10	17	*17.5*	1 to 3 months	24	*24.7*
11 and above	8	*8.3*	3 months and above*	31	*32.0*
Total	97	*100.0*	Total	97	*100.0*

*Social work involvement was still continuing with 12 clients in April 1981.

cal, as well as health, problems (Shepherd *et al.*, 1964; Shepherd *et al.*, 1966; Eastwood and Trevelyan, 1972; Lamberts, 1979). Some doctors may refer to health visitors or deal themselves with problems which might otherwise be referred to social workers (Cooper *et al.*, 1975; Williams and Clare, 1979). Others may find difficulty in identifying them in the first place (Reilly *et al.*, 1977).

It is probable, however, that most of the general practitioners had little understanding of the social work role, or that where they did they had little faith in social workers' ability to deal with non-practical matters (McCulloch and Brown, 1970; Theophilus, 1973). Without this understanding, the general practitioners will have fallen back on criteria based on their own medical training and experience to decide when to make referrals. This explanation is consistent with experience gained from attachment schemes, where social workers felt they needed to increase the doctors' understanding of their role (McCulloch and Brown, 1970; Williams and Clare, 1979). Certainly, had the general practitioners known about or had more confidence in psychodynamic social work skills, more referrals might have been expected in this area. Different doctors may manage these problems in different ways, but some low-referring general practitioners may respond by prescribing drugs (Raynes, 1980).

Official reports have stressed that a fully holistic approach to individual welfare requires full co-operation and good communication between doctors and social workers (DHSS, 1968, 1974; Hicks, 1976). Experience shows that both joint education of social workers and general practitioners during training and attachment schemes significantly improve co-operation (Foreman and Fairbairn, 1968; Goldberg and Neill, 1972; Royal College of General Practitioners and the British Association of Social Workers, 1978; Salkind and Norell, 1980). These strategies are, no doubt, the best way forward in the immediate future. However, it is a matter of concern that, 10 years after the establishment of social service departments, a professional group such as general practitioners, whose work overlaps consistently with that of social workers, are apparently unclear about the social work role. However, this is a characteristic they share with other groups (Glampson and Goldberg, 1976; Glampson *et al.*, 1977; Rees, 1978).

In part, this confusion no doubt reflects the failure of social work to establish clearly and convincingly its professional role and credentials (British Association of Social Workers, 1977; Howe, 1980). However, social service departments often appear distant, intimidating and opaque (Glampson and Goldberg, 1976; Rees, 1978). Social workers' functions are often not easy to differentiate from those of other workers employed in social services whose roles are generally more practical. Furthermore, the bureaucratic structure and setting of the social work agency inevitably foster a bureaucratic image (Prodgers, 1979; Hadley and McGrath, 1979). In this context, it is interesting that the more straightforward administrative work of mobilizing resources should be requested so much more than the more sophisticated psychodynamic skills. It is probable, therefore, that the agency setting tends to conceal rather than clarify the role of social workers, and some general practitioners may thereby remain sceptical about the value of social work (Mid Glamorgan County Council, 1978). Furthermore, because so many potential clients are reluctant to be referred to social workers in social service departments (Rees, 1978; Goldberg, 1979), it may be that a change in agency structure or setting is necessary if social workers are to be fully used.

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Note

The views presented here are those of the author, and do not necessarily represent the views of Norfolk Social Service Department.

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